

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CLINICAL COMMISSIONING GROUP OUTCOMES INDICATOR SET (CCG OIS) INDICATOR DEVELOPMENT PROGRAMME

Consultation report on potential CCG OIS indicator(s)

CCG OIS indicator area: Maternity

Consultation period: 03/02/2014 – 03/03/2014

Potential output: Recommendations for NICE menu

Introduction

The following report provides a summary of the responses received from the recent consultation on potential new indicators for the 2015/16 Clinical Commissioning Group Outcomes Indicator Set (CCG OIS). The Committee is asked to consider the results of consultation alongside testing reports produced by the Health and Social Care Information Centre.

Indicator(s) included in the consultation

| ID | Indicators | Domain | Overarching/ Improvement area | Evidence source |
|--------|-----------------------------------------------------------------|--------|----------------------------------------------|------------------------------------------------------------------------------------------------------|
| IND-15 | The proportion of pregnancies resulting in a still birth | 1 | Reducing deaths in babies and young children | NICE quality standard 22 Antenatal care (2012) and NICE quality standard 32 Caesarean Section (2013) |
| IND-16 | The proportion of births where the child has a low birth weight | 1 | Reducing deaths in babies and young children | NICE quality standard 22 Antenatal care (2012) and NICE quality standard 32 Caesarean Section (2013) |

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| IND-17 | The proportion of births resulting in a neonatal unit admission | 1 | Reducing deaths in babies and young children | NICE quality standard 22 Antenatal care (2012) and NICE quality standard 32 Caesarean Section (2013) |
| IND-18 | The proportion of births resulting in a postnatal unit admission | 1 | Reducing deaths in babies and young children | NICE quality standard 22 Antenatal care (2012) and NICE quality standard 32 Caesarean Section (2013) |

Summary of consultation responses

IND-15: The proportion of pregnancies resulting in a still birth.

One stakeholder highlighted the potential value of this indicator.

Some stakeholders commented that they were unsure on the usefulness of this indicator at a CCG level.

A stakeholder also queried what definition of still birth would be used, noting differences between the current standard UK definition (any baby born dead after 24 weeks) and the WHO/Lancet series being of 28+ weeks.

Some stakeholders commented that this indicator would have lower impact than IND-16 (low birth weight). Another stakeholder queried whether the numbers would be large enough at CCG level to provide statistical confidence. It was highlighted still births are not necessarily due to a lack of care therefore great caution is needed when analysing results.

IND-16: The proportion of births where the child has a low birth weight.

Some stakeholders commented that this indicator was the most important within this set (IND-15 to IND-18). Other stakeholders also supported the inclusion of this indicator in the CCG OIS highlighting its potential value.

One stakeholder highlighted low birth weight is an indicator of potential poor development of the child, but would not wholly reflect poor antenatal care. Therefore great caution is needed when analysing results.

A stakeholder also commented that low birth weight is not only because of poor antenatal care, twins are often of low birth weight and thrive. If an area has a high IVF rate (for instance if multiple IVF cycles are funded) then there might be a higher proportion of low weight babies because of a higher risk of multiple births.

A stakeholder also requested further clarity over the definition of low birth weight.

IND-17: The proportion of births resulting in a neonatal unit admission.

Some stakeholders requested clarity over the target population for this indicator in terms of whether all new born babies would be included or just full term babies. Stakeholders also commented that they were unclear on the intent of this indicator as a proxy outcome for maternity care.

A stakeholder also highlighted poorer antenatal and delivery of clinical care can result in a higher proportion of babies admitted to neonatal units. However they suggested a potential problem with analysing may be that the patterns of neonatal unit admission can be influenced by social deprivation and different levels of population lifestyle behaviour such as levels of alcohol consumption that affects the developing unborn child.

NHS England commented a rise in neonatal unit admissions may rise because of better recognition of babies in need of extra care and does not necessarily suggest problems in care. Another stakeholder also highlighted the results of this indicator could be influenced for reasons other than maternity outcome.

IND-18: The proportion of births resulting in a postnatal unit admission.

As with some of the other maternity indicators consulted on in this set (IND-15 to IND-18) some stakeholders commented that the results could be influenced by factors other than maternity care.

A stakeholder also queried how useful this indicator would be as a proxy measure for maternity care outcomes.

Comments were also received from stakeholders over the definitions used for this indicator and one stakeholder was unsure what a postnatal unit is. One stakeholder queried if admissions to neonatal units would count against this indicator or if transitional care would also count. The same stakeholder requested clarity over whether the indicator relates to the baby, mother or both.

Consultation comments

| ID | Stakeholder organisation | Comment |
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| IND-15 | NHS Stockport CCG | Less good in terms of impact than IND16 |
| IND-15 | Kirklees Public Health Intelligence | Stillbirth rates not changed signif in recent years. Not sure how useful this would be at CCG level (low numbers?) |
| IND-15 | NHS Wigan Borough CCG | Although numbers are a little higher, the issue of statistical confidence in this dataset may be similar to those raised around Asthma and Meningitis mortality. For example, in the Wigan MCD area there were 22 still births recorded in 2011 and 28 recorded in 2012. In percentage terms, this is a year-on-year rise of over 21% but in absolute terms a rise of 6. |
| IND-15 | NHS West Essex CCG | <p>In terms of extent of influence by the CCG, although achievement by providers of the NICE Quality Standards for antenatal care and c-section might help, a significant amount of conditions determining still birth incidence (e.g. IUGR) are driven by smoking/association with socioeconomic deprivation – more with the local authorities' public health role (i.e. out of the CCG's sphere of influence?)</p> <p>This metric is also linked to IND 4 and 5 where prompt access to antenatal care starting early in pregnancy may effect outcome.</p> |
| IND-15 | British Thyroid Foundation | <p>Iodine Deficiency (ID) is present in around two-thirds of pregnant women in UK. The deficiency is mild to moderate (urinary iodine <150µg/L which is WHO and ICCIDD recommended lower level for optimal iodine nutrition in pregnancy).</p> <p>There is some evidence that iodine deficiency is a factor in the cause of preterm birth, miscarriage, fetal growth restriction and still birth.</p> <p>A clinical commissioning group could influence these outcomes by advocating adequate iodine nutrition in pregnancy either by recommending provision of iodine supplements or ensuring adequate supplies of iodised salt in UK. Currently there is no legislation for the use of iodised salt as there is in many countries in the world. Less than 5% of salt in UK is iodised. Preferably both strategies for iodine fortification should be advocated.</p> <p>Iodine supplementation is cost effective and can be readily implemented. Barriers include public reluctance to take pills in pregnancy and concern (considered to be unjustified about adding a micronutrient to salt).</p> <p>WHO/ICCIDD has stated that the upper limit for urinary iodine in pregnancy should be 500µg/L. This would be attained in very few women as most are deficient. The potential harm of this and higher levels is transient hyperthyroidism or</p> |

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| | | <p>hypothyroidism. The benefits are a reduction in the outcomes referred to.</p> <p>There is minimal potential for indicator to impact on any particular group. It would probably benefit Vegans to a greater extent as they are nearly all iodine deficient.</p> <p>References</p> <p>Jiskra J, Fait T, Bílek R, Krátký J, Bartáková J, Lukáš J, Límanová Z, TeličkaZ, Zamrazil V, Potluková E. Mild iodine deficiency in women after spontaneous abortions living in an iodine-sufficient area of Czech Republic: prevalence and impact on reproductive health. Clin Endocrinol (Oxf). 2014 Mar;80(3):452-8.</p> <p>Korevaar TI, Schalekamp-Timmermans S, de Rijke YB, Visser WE, Visser W, deMuinck Keizer-Schrama SM, Hofman A, Ross HA, Hooijkaas H, Tiemeier H, Bongers-Schokking JJ, Jaddoe VW, Visser TJ, Steegers EA, Medici M, Peeters RP. Hypothyroxinemia and TPO-antibody positivity are risk factors for premature delivery: the generation R study. J Clin Endocrinol Metab. 2013 Nov;98(11):4382-90.</p> <p>Stagnaro-Green A, Pearce E. Thyroid disorders in pregnancy. Nat Rev Endocrinol. 2012 Nov;8(11):650-8</p> <p>Obican SG, Jahnke GD, Soldin OP, Scialli AR. Teratology public affairs committee position paper: iodine deficiency in pregnancy. Birth Defects Res A Clin Mol Teratol. 2012 Sep;94(9):677-82</p> <p>Belfort MB, Pearce EN, Braverman LE, He X, Brown RS. Low iodine content in the diets of hospitalized preterm infants. J Clin Endocrinol Metab. 2012 Apr;97(4):E632-6.</p> <p>Zimmermann MB. The role of iodine in human growth and development. Semin Cell Dev Biol. 2011 Aug;22(6):645-52.</p> <p>Rayburn WF, Robinson A, Braverman LE, He XM, Pino S, Gargas ML, Kinzell JH. Iodide concentrations in matched maternal serum, cord serum, and amniotic fluid from preterm and term human pregnancies. Reprod Toxicol. 2008 Jan;25(1):129-32.</p> <p>Ares S, Escobar-Morreale HF, Quero J, Durán S, Presas MJ, Herruzo R, Morreale de Escobar G. Neonatal hypothyroxinemia: effects of iodine intake and premature birth. J Clin Endocrinol Metab. 1997 Jun;82(6):1704-12.</p> |
| IND-15 | NHS Bristol CCG | We note the indicator and its potential value, and have no further comments at this stage. |
| IND-15 | Outcomes Based Healthcare Ltd | <p>Summary: Outcome, but unclear what the population sample is.</p> <p>Important outcome. However, what is the definition of still birth being used in this instance? Is it the standard UK definition of any baby born dead after 24 weeks, or the WHO/Lancet series of 28+ weeks used elsewhere? Assume the former, but since no definition is offered it is hard to comment.</p> <p>Q: Is there a reason why miscarriage is referred to under this indicator? Miscarriages are not usually classified as still</p> |

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| | | births, so it is unclear what this reference is referring to. |
| IND-15 | Somerset CCG | <p>The proportion of pregnancies resulting in a still birth</p> <p>Which indicators have the greatest potential to contribute against the domain objectives and improvement areas of the NHS Outcomes Framework?</p> <p>Small numbers - so not a huge potential contribution. Counting does not mean changing what happens , there is no aspect of measuring intervention in this.</p> |
| IND-15 | Somerset CCG | <p>Maternity: The proportion of pregnancies resulting in a still birth.</p> <p>To what extent do the indicators reflect aspects of care with unacceptable variations?</p> <p>Stillbirths are not necessarily a result of lack of care</p> |
| IND-16 | NHS Stockport CCG | We support this indicator in preference to the others (similar commends to IND2 in terms of CCG control) |
| IND-16 | Kirklees Public Health Intelligence | Low birth weight of term babies (PHOF) seems more appropriate than all babies? |
| IND-16 | NHS West Essex CCG | Please see above |
| IND-16 | British Thyroid Foundation | <p>Iodine Deficiency (ID) is present in around two-thirds of pregnant women in UK. The deficiency is mild to moderate (urinary iodine <150µg/L which is WHO and ICCIDD recommended lower level for optimal iodine nutrition in pregnancy).</p> <p>There is some evidence that iodine deficiency is a factor in the cause of preterm birth, miscarriage, fetal growth restriction and still birth.</p> <p>A clinical commissioning group could influence these outcomes by advocating adequate iodine nutrition in pregnancy either by recommending provision of iodine supplements or ensuring adequate supplies of iodised salt in UK. Currently there is no legislation for the use of iodised salt as there is in many countries in the world. Less than 5% of salt in UK is iodised. Preferably both strategies for iodine fortification should be advocated.</p> <p>Iodine supplementation is cost effective and can be readily implemented. Barriers include public reluctance to take pills in pregnancy and concern (considered to be unjustified about adding a micronutrient to salt).</p> <p>WHO/ICCIDD has stated that the upper limit for urinary iodine in pregnancy should be 500µg/L. This would be attained in very few women as most are deficient. The potential harm of this and higher levels is transient hyperthyroidism or</p> |

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| | | <p>hypothyroidism. The benefits are a reduction in the outcomes referred to.</p> <p>There is minimal potential for indicator to impact on any particular group. It would probably benefit Vegans to a greater extent as they are nearly all iodine deficient.</p> <p>References</p> <p>Jiskra J, Fait T, Bílek R, Krátký J, Bartáková J, Lukáš J, Límanová Z, TeličkaZ, Zamrazil V, Potluková E. Mild iodine deficiency in women after spontaneous abortions living in an iodine-sufficient area of Czech Republic: prevalence and impact on reproductive health. Clin Endocrinol (Oxf). 2014 Mar;80(3):452-8.</p> <p>Korevaar TI, Schalekamp-Timmermans S, de Rijke YB, Visser WE, Visser W, deMuinck Keizer-Schrama SM, Hofman A, Ross HA, Hooijkaas H, Tiemeier H, Bongers-Schokking JJ, Jaddoe VW, Visser TJ, Steegers EA, Medici M, Peeters RP. Hypothyroxinemia and TPO-antibody positivity are risk factors for premature delivery: the generation R study. J Clin Endocrinol Metab. 2013 Nov;98(11):4382-90.</p> <p>Stagnaro-Green A, Pearce E. Thyroid disorders in pregnancy. Nat Rev Endocrinol. 2012 Nov;8(11):650-8</p> <p>Obican SG, Jahnke GD, Soldin OP, Scialli AR. Teratology public affairs committee position paper: iodine deficiency in pregnancy. Birth Defects Res A Clin Mol Teratol. 2012 Sep;94(9):677-82</p> <p>Belfort MB, Pearce EN, Braverman LE, He X, Brown RS. Low iodine content in the diets of hospitalized preterm infants. J Clin Endocrinol Metab. 2012 Apr;97(4):E632-6.</p> <p>Zimmermann MB. The role of iodine in human growth and development. Semin Cell Dev Biol. 2011 Aug;22(6):645-52.</p> <p>Rayburn WF, Robinson A, Braverman LE, He XM, Pino S, Gargas ML, Kinzell JH. Iodide concentrations in matched maternal serum, cord serum, and amniotic fluid from preterm and term human pregnancies. Reprod Toxicol. 2008 Jan;25(1):129-32.</p> <p>Ares S, Escobar-Morreale HF, Quero J, Durán S, Presas MJ, Herruzo R, Morreale de Escobar G. Neonatal hypothyroxinemia: effects of iodine intake and premature birth. J Clin Endocrinol Metab. 1997 Jun;82(6):1704-12.</p> |
| IND-16 | NHS Heywood, Middleton and Rochdale CCG | The CCG consider this to be the most important indicator in this section |
| IND-16 | NHS Bristol CCG | We note the indicator and its potential value, and have no further comments at this stage. |
| IND-16 | Outcomes Based Healthcare Ltd | <p>Summary: Outcome.</p> <p>Assume standard definition of low birth weight.</p> |

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| IND-16 | Somerset CCG | <p>Maternity: The proportion of births where the child has a low birth weight.</p> <p>Which indicators have the greatest potential to contribute against the domain objectives and improvement areas of the NHS Outcomes Framework?</p> <p>Low birth weight is not only because of poor antenatal care, twins are often of low birth weight and thrive. If an area has a high IVF rate (for instance if multiple IVF cycles are funded) then there might be a higher proportion of low weight babies because of a higher risk of multiple births.</p> |
| IND-16 | Somerset CCG | <p>To what extent can the indicators be influenced by the actions of clinical commissioning groups for example through decisions on which services to commission, the setting of contracts and the monitoring of the quality of services commissioned from providers?</p> <p>IVF provision</p> <p>Improving smoking cessation work among women of child bearing age</p> |
| IND-16 | Somerset CCG | <p>To what extent do the indicators reflect aspects of care with unacceptable variations?</p> <p>Low birth weight is an indicator of potential poor development of the child, but might not wholly reflect poor antenatal care</p> |
| IND-17 | NHS Stockport CCG | Could be influenced for reasons other than maternity outcome |
| IND-17 | Kirklees Public Health Intelligence | How useful as proxy measure for maternity care outcomes (no distinction between pre- and full-term babies)??? NHSOF 5.5 (admission of full-term babies to neonatal care more useful indicator?) |
| IND-17 | NHS England | Admissions could rise due to better recognition of babies in need of extra care rather than an increase in problems in care. |
| IND-17 | NHS Bristol CCG | We note the indicator and its potential value, and have no further comments at this stage. |
| IND-17 | Eastbourne Hailsham and Seaford CCG and Hastings and Rother CCG | Clarity re definition – term babies or all babies? How will we ensure consistency of data from providers? |
| IND-17 | Outcomes Based Healthcare Ltd | <p>Summary: Process, not an outcome.</p> <p>It would be helpful to understand the rationale for this process indicator being considered an important proxy outcome for maternity care outcomes. It is not currently clear from the explanation given in the document that this is necessarily</p> |

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| | | the case. |
| IND-17 | Somerset CCG | <p>Maternity: The proportion of births resulting in a neonatal unit admission.</p> <p>Which indicators have the greatest potential to contribute against the domain objectives and improvement areas of the NHS Outcomes Framework?</p> <p>Low birth weight is not only because of poor antenatal care, twins are often of low birth weight and thrive. If an area has a high IVF rate (for instance if multiple IVF cycles are funded) then there might be a higher proportion of low weight babies because of a higher risk of multiple births.</p> |
| IND-17 | Somerset CCG | <p>To what extent can the indicators be influenced by the actions of clinical commissioning groups for example through decisions on which services to commission, the setting of contracts and the monitoring of the quality of services commissioned from providers?</p> <p>IVF provision</p> <p>Improving smoking cessation work among women of child bearing age</p> |
| IND-17 | Somerset CCG | <p>To what extent do the indicators reflect aspects of care with unacceptable variations?</p> <p>Poorer antenatal and delivery care can result in a higher proportion admitted, but the pattern might be obscured by different levels of population lifestyle behaviour that affects the developing child</p> |
| IND-17 | Somerset CCG | <p>What (if any) are the potential unintended consequences that might result from implementing the indicators?</p> <p>Redefining what a neonatal unit admission is?</p> |
| IND-18 | NHS Stockport CCG | Could be influenced for reasons other than maternity outcome |
| IND-18 | Kirklees Public Health Intelligence | How useful as proxy measure for maternity care outcomes??? |
| IND-18 | NHS England | Admissions could rise due to better recognition of babies in need of extra care rather than an increase in problems in care. |
| IND-18 | NHS Bristol CCG | We note the indicator and its potential value, and have no further comments at this stage. |
| IND-18 | Eastbourne Hailsham and Seaford CCG and Hastings and | Clarity re post natal unit admission is this to neonatal unit or does transitional care count? does this relate to baby, mother or both? |

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| | Rother CCG | |
| IND-18 | Outcomes Based Healthcare Ltd | <p>Summary: Process, not an outcome.</p> <p>It would be helpful to understand the rationale for this process indicator being considered an important proxy outcome for maternity care outcomes. It is not currently clear from the explanation given in the document that this is necessarily the case.</p> |
| IND-18 | Somerset CCG | <p>Maternity: The proportion of births resulting in a postnatal unit admission.</p> <p>What (if any) are the potential barriers to implementing the indicators?</p> <p>Same comments as previous column - not sure what a postnatal unit is - never heard of them. Might this be an issue in the indicator definition? Would some areas have a combined neonatal/postnatal unit? why not have a single indicator that says admission to either?</p> |
| General | Leeds City Council Public Health team | <p>I would favour the ones reducing low birth weight and stillbirths, as they cover broad programmes which can be influenced by primary care, commissioned services and developmental work (rather than just commissioned services) so I think they are stronger measure of overall CCG outcomes. Of the maternity ones, I would favour the reduction in late booking after 20 weeks, which again can be influenced by partnership and developmental programmes as well as commissioning eg health equity audit work and targeted initiatives at vulnerable populations. I am not sure of the rationale for pulling booking forward to 10 weeks which will be very difficult, and will result in booking more women who sadly miscarry early in pregnancy. We have worked to 12 completed weeks to date, which is early enough for Down's screening and early scans.</p> |
| General | Roche Diagnostics | <p>With the recent introduction of a new payment system for the delivery episode and antenatal care, we support the introduction of quality/outcome indicators in this pathway as a priority.</p> |
| General | National LGB&T Partnership | <p>A lack of patient sexual orientation and gender identity monitoring across the healthcare system means that the needs of lesbian, gay, bisexual and trans (LGB&T) people will not be recognised within this indicator, resulting in adverse impact on these protected characteristics groups. LGB&T people experience a range of health inequalities compared to the general population (see the Public Health Outcomes Framework LGB&T Companion Document for a presentation of the evidence: www.lgf.org.uk/phof) and if their needs are not recognised in resources such as the CCG OIS, there is a risk that they will not be acknowledged in service design and delivery, leading to continued inequalities. A continued lack of monitoring affects the ability of CCGs and others in the healthcare system to understand populations and direct interventions and services effectively. NICE should work where it can to influence leaders in the healthcare system to implement comprehensive and consistent patient sexual orientation and gender identity monitoring. CCGs should also be encouraged to take account of local need (presented in documents such as the JSNA) and not focus solely on these indicators at a broad level. Otherwise there is a risk of locally pertinent issues being ignored, such as LGB&T health.</p> |

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| General | The Lesbian and Gay Foundation | A lack of patient sexual orientation and gender identity monitoring across the healthcare system means that the needs of lesbian, gay, bisexual and trans (LGB&T) people will not be recognised within this indicator, resulting in adverse impact on these protected characteristics groups. LGB&T people experience a range of health inequalities compared to the general population (see the Public Health Outcomes Framework LGB&T Companion Document for a presentation of the evidence: www.lgf.org.uk/phof) and if their needs are not recognised in resources such as the CCG OIS, there is a risk that they will not be acknowledged in service design and delivery, leading to continued inequalities. A continued lack of monitoring affects the ability of CCGs and others in the healthcare system to understand populations and direct interventions and services effectively. NICE should work where it can to influence leaders in the healthcare system to implement comprehensive and consistent patient sexual orientation and gender identity monitoring. CCGs should also be encouraged to take account of local need (presented in documents such as the JSNA) and not focus solely on these indicators at a broad level. Otherwise there is a risk of locally pertinent issues being ignored, such as LGB&T health. |
| General | Kirklees Public Health Intelligence | IND16 the key indicator out of the above 4 indicators proposed? |
| General | NHS Wigan Borough CCG | There is a possibility that statistical issues, such as those highlighted above, may result in incorrect and/or inappropriate conclusions and observations being formed if this indicator was to be performance managed at CCG level. The indicator is wholly appropriate to be considered at NHS Outcomes Framework level, but whether it is similarly appropriate to be considered for CCG OIS is open to question. |
| General | NHS Heywood, Middleton and Rochdale CCG | These indicators should be checked for cross overs with the Public Health Outcomes Framework |
| General | Epilepsy Action | Preconception counseling (for women with epilepsy and other medical conditions and taking teratogenic medication) is vital to reduce fetal death and neonatal admissions due to malformation, and need for ongoing support in child and adulthood due to neurodevelopment impairment. Preconception counseling is an opportunity for women to plan their pregnancies after steps to optimize their treatment (to more adequately control their medical condition while potentially reducing the exact risk of teratogenicity) have been introduced. It is also an additional opportunity to inform women of symptoms in pregnancy or post pregnancy that require urgent medical attention. |
| General | Outcomes Based Healthcare Ltd | Q: Is there a reason why these aren't clustered with the antenatal indicators? |